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The Mental Health Nurse Role in the Near-death Experience

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Running Head: NDE

The Mental Health Nurse Role in the Near-death Experience

In the past, much attention has been paid to avoid labeling the person who has had a near-death experience (NDE) with a psychological condition (Moody, 1976; Ring, 1980). Numerous researchers (Moody, 1976; Ring, 1980, 1984a; Strom-Paikin, 1986) of near-death studies have stressed that although the phenomenon is not believed to be a result of psychopathology, the repercussion of having an NDE can cause adjustment problems for the near-death experiencer (NDER). NDERs have reported a sense of alienation from others and from their previously held concept of themselves (Strom-Paikin, 1986). Accounts (Greyson & Bush, 1992) of distressing NDEs are more prevalent than previously believed and due to their traumatic nature may be even more difficult for the NDER to work through. Mental health nurses are the ideal resource to assist with these clients and more attention needs to be directed toward assessing for a possible NDE. It is important for mental health nurses to become involved with NDE clients whether in or outside of a psychiatric setting. Helping clients adjust to life changes and their emotional impacts, self-concept issues, and working through traumatic experiences are all relevant to mental health nursing.

Although there has been an avoidance of labeling the NDE as a psychological condition, research has been conducted investigating the psychological aspects of the NDER and the NDE. A survey of 117 Illinois psychiatrists found that 19% had

counseled clients who had had NDEs (Walker & Russell, 1989). In a study conducted to examine commonalties of NDErs, researchers tentatively suggested that the phenomenon may occur "more frequently" (Ring & Rosing, 1990, p. 221) in persons who experienced childhood trauma and abuse and as a result may be prone to dissociative episodes. In studying distressing types of NDEs, researchers (Greyson & Bush, 1992) speculated that these may represent an atypical form of post-traumatic stress disorder (PTSD). The psychological implications associated with the near-death phenomena are readily seen through this brief description of the current research in the field.

The background information in this article is provided to stimulate interest in the near-death population and to encourage mental health nursing's involvement in assisting the NDEr in all practice settings. The article includes a brief overview of the NDE and describes two specific areas where the mental health nurse may see the NDEr in the mental health practice setting: after a failed suicide attempt, and after experiencing a distressing NDE. The final portion of the article describes how the NDE relates to the PTSD diagnostic criteria.

Background information

The near-death experience has become a more common phenomenon than what was once suggested. Of persons who have come close to death, approximately 35 to 40% have had a NDE (Ring, 1984a). These numbers may still not accurately reflect

the total population that experiences the phenomenon. Reasons cited for the reluctance of NDErs to relate their accounts have been an inability to describe the experience or "ineffability" (Moody, 1976), as well as the fear of being thought mentally unstable by admitting to such an experience.

Until recently the typical NDE was described as predominantly pleasant and following a fairly consistent pattern. A progressional five stage model (Ring, 1980, 1984b) was developed to describe the core experience:

1. The first stage is an affective component, describing feelings that are peaceful and tranquil. These feelings are believed to be the initial cue for the NDE to begin and are continuous throughout the experience.

2. The second stage involves an out-of-body experience or a feeling of separation from the physical body.

3. The third stage is a transitional stage, characterized by a feeling of moving rapidly through darkness. Many NDErs have described this sensation as a feeling of moving through a dark tunnel. Occasionally NDErs have sensed a presence while in this stage.

4. The fourth stage includes seeing a golden light that brings the NDEr out of the darkness of the previous stage and envelops the NDEr with continued feelings of tranquility.

5. The final stage is different from stage four as the NDEr has entered the golden light. There is a predominant feeling of

being in a supernal or other world. Previously felt presences are now seen and many NDErs report being greeted by deceased relatives and other figures.

The five stages of the core NDE have been studied (Ring, 1980, 1984b; Grey, 1985) with three specific groups of clients who have been near death: illness survivors, accident victims, and suicide attempters. Researchers found that the presence of all five stages differed with the three types of NDErs studied. Illness survivors had a more complete unfolding of all five stages of the core experience. Accident victims sometimes experienced all five stages but the presence of the final two stages were rarer for these individuals. Suicide attempters were noted to have a total absence of stage four and five core experiences. This discrepancy in the core experience for suicide attempters suggested to the researchers that the NDE may fade out before completion.

Suicide and the NDE

The occurrence of a NDE with a suicide attempt has received special focus in the research on NDEs. The incidence was studied by Greyson (1986), who found that from a sample of 61 patients hospitalized after attempting suicide, 26.2% reported having a NDE. The incidence of a NDE is further lowered if the suicide attempt was associated with the ingestion of alcohol or other drugs (Greyson & Stevenson, 1980).

The relationship between the presence of a NDE and repeated

suicide attempts has received moderate attention in the literature (Ring, 1980). Greyson (1984) described some fear expressed by researchers that a positive NDE might increase the suicide rate; the implication was that the positive NDE would lure a person toward suicide. However, other researchers (Greyson, 1984; Moody, 1976) implied that the NDE for suicide attempters could be so unpleasant that it might decrease the desire of these individuals to repeat their actions. Conversely, Ring (1980) found that the presence of a NDE with a suicide attempt did not coincide with a decrease in future suicidal behavior. Attempting suicide does not eliminate the possibility of having a positive NDE; likewise, distressing NDEs are not limited only to suicide attempters.

Peaceful versus Distressing NDEs

The majority of the NDE literature has rarely included accounts of "negative" near-death experiences. Zaleski (1987) provided an extensive review of NDEs accounts from medieval descriptions to the present. Negative or distressing NDEs were glaringly absent from the modern reports in comparison to the great number of reports from previous centuries. Until recently suggestions of negative or distressing NDEs were considered rare and were reported to represent only about 1% of reported NDEs (Ring, 1984a).

The decreased number of reports of distressing NDEs might be explained by the choice of terminology used to describe the

different types of NDEs (Greyson & Bush, 1992). This terminology qualified the NDE as "bad or negative" versus "good or positive." Past research has indicated NDErs' reluctance to report the incident, and it is possible that a disturbing NDE could be even less likely to be reported. This has prompted a change in the terminology from "good or bad" to "peaceful or distressing," more accurately depicting the affective component of the NDE.

Grey (1985) provided detailed information about negative experiences and characterized the core experiences by five categories. The first category differs from the Ring model (1980, 1984b) as the affective component feelings are of fear and panic rather than peace and calm. The second category is similar to Ring's, also containing out-of-body experiences. The third category is described as entering a black void. This is qualitatively different from the darkness sensation of the Ring model as this experience continues to elicit frightening feelings in the NDEr. The fourth feature is the sensing of an evil force, which leads to the fifth feature of entering a "hell-like" environment (Grey, 1985, p. 72) instead of the ethereal beauty of the Ring model.

Three Types of Distressing NDEs

The most recent study concerning "distressing" NDEs (Greyson & Bush, 1992) found three predominant categories. The core experiences of the first type of "distressing" NDE was very similar to that of the "peaceful" NDE; it was the individual's

interpretation of the event that was seen as terrifying. The affective change is associated with the NDErs' feeling a loss of control over their experiences which were personally interpreted as frightening. Their distressing feelings were self-limiting and did not persist, either converting to peaceful feelings within the NDE or later, upon reflection on the occurrence.

The second "distressing" type of NDE was encountering a void or nothingness. Respondents described this as feeling terrified that their lives not only ceased to exist in the present, but that they never existed at all. NDErs reported mocking voices denouncing their lives. Study participants often believed they were trying to prove to these "voices" that their lives existed at all. These NDEs did not convert to peaceful feelings in the course or aftermath of the experience. NDErs reported that the experiences left them with feelings of "emptiness and fatalistic despair" (p.104).

The third type of "distressing" NDE included nightmarish scenes, replacing the beautiful other world of the fifth stage in Ring's core NDE description with "...graphic hellish symbolism, such as threatening demons or falling into a dark pit" (p. 105). Although it is presently believed that pleasant NDEs (Greyson & Bush, 1992, p. 107) "...rarely lead to psychiatric evaluation or treatment," what does this suggest concerning those individuals experiencing distressing NDEs? Is the experience of either type of NDE, distressing or pleasant, sufficient to traumatize the

person so that they fit into the PTSD criteria?

PTSD and NDE

The Diagnostic and Statistical Manual of Mental Disorders (DSM) lists five criteria necessary for a PTSD diagnosis:

1. Experiencing a traumatic event.
2. Persistently reexperiencing the traumatic event.
3. Duration of one month.
4. Persistent avoidance of event associated stimuli.
5. Persistent symptoms of increased arousal.

At present the NDE meets the first three of the five required PTSD diagnostic criteria.

The first criterion is further described as a condition in which the individual undergoes an event (American Psychiatric Association, 1987, p. 146) "...that is outside the range of usual human experience and that would be markedly distressing to almost anyone." This is usually associated with threats to life, unexpected destruction, or violence. The NDE conforms with the preliminary criterion for PTSD because it is associated with a serious threat to the NDEr's life.

The second criterion ascribes a negative or distressing quality to the persistent reexperience of the traumatic incident. After the event, NDErs report daily preoccupation with death (Strom-Paikin, 1986), but only those who have experienced distressing NDEs describe this as a fear of death. Since the NDE encompasses two events, one of coming close to death and the

other of the core experience, it is hard to separate the two. The challenge in meeting the PTSD criteria comes in defining the reoccurrence of the core experience as distressing. For those who experienced pleasant NDEs or have a distressing NDE convert to pleasant, the criterion is not so clear cut as for those whose experience began and continues to be distressing. This distressing quality assigned to reexperiencing the event complicates this criterion. Would persistent daily intrusions by their own natures be distressing enough to fit this criterion?

The third criterion that the NDE meets is that of duration, which states that the symptoms must be present one month before a PTSD diagnosis can be made. Besides the daily preoccupation with the event, NDErs have been known to wait years before ever recounting the experience to another person (Moody, 1976).

Two criteria remain that the NDE does not completely satisfy to make the PTSD diagnosis. The first of these is the persistent avoidance of event-associated stimuli. The criterion provides seven possible responses, three are needed in order to make the diagnosis. The research conducted so far has indicated that the NDE meets only one of three requirements, that of the individual feeling detached or estranged from others due to the traumatic event. NDErs report their experiences leave them feeling they no longer fit into society (Strom-Paikin, 1986). Of the remaining six possible responses for this criterion, a weak supposition could be made that the inability by some NDErs to recall their

experiences might relate to a psychogenic amnesia. Studies have not addressed whether NDErs try to avoid thoughts, feelings, activities or other situations associated with their experience. Finally, the remaining criterion, persistent symptoms of increased arousal has not been researched or associated with the NDE at this time. The need to conduct further research is apparent in order to support the inclusion of the NDE into a PTSD diagnosis or in creating a new DSM classification that would encompass the changes that occur in the individual who has had the NDE.

Assessing and Treating

The NDErs' reactions concerning their experiences are individualized. For one person it may be an interesting occurrence, while to another it may be an irreconcilable feeling of personal change that no longer fits their previously held roles (Grey, 1985; Ring, 1980; Strom-Paikin, 1986). Kellehear (1990) suggested that the NDE's importance is in the meaning the NDEr applies to the event. This concept can be helpful in assisting clients in and out of the psychiatric setting.

Mental health nurses need to be aware that their clients may have been affected by a NDE. A thorough assessment should include the possibility of a NDE occurring during a suicide attempt. Do not assume that if a client does not reveal the experience, that it has not occurred. Ask the client open ended questions about whether they experienced anything out of the

ordinary during their brush with death. Mental health nurses need to assure clients that NDEs are not uncommon among individuals who were close to death, which can help the client normalize the event (Strom-Paikin, 1986). Providing unconditional acceptance is the vanguard of the mental health nurse and will assist the NDEr to feel less isolated by the experience. Do not be in a hurry to provide background information on the NDE; instead, allow the client to express what has occurred, especially feelings during and after the event. Let the client set the pace of disclosure. Mental health nurses should also be aware that NDEs remain constant over time (Greyson, 1986) and as such they may have occurred anytime in the client's life span. Making these assessments may assist the NDEr to assimilate the experience in a healthy manner.

Summary

The NDE has been a subject of research for the last 25 years, and many questions remain unanswered concerning the phenomenon. The one certainty of all the research is that the NDE has a psychological implication for the experiencer. The research has also shown that the NDE can occur in many practice settings from the emergency room, intensive and coronary care units, medical and surgical units, to maternity units, and the continued impact on the NDEr transcends these settings. Distressing NDEs reportedly leave the client feeling fearful of death, possibly impacting the client's future hospitalization or

medical needs. Assessing for an NDE can provide useful information in assisting clients who have had the experience and to shed more light on the phenomenon as it pertains to the mental health arena. The information provided in this article has addressed three specific areas pertinent to mental health nursing: suicide and the NDE, distressing NDEs, and NDE as a PTSD diagnosis. Mental health nurses need to communicate their availability as a resource to other health care providers in working with the NDE client. The unique therapeutic interpersonal skills of the mental health nurse can and should be utilized with the NDE client in all practice settings.

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